

LETTER TO EDITOR

Operationalizing the 2024 International Health Regulation (IHR) Amendments for Disaster and Emergency Health; a Letter to the Editor

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Dear Editor,

The International Health Regulations (IHR) remain the central legal instrument for managing cross border public health risks and coordinating international responses to crises. Recent amendments adopted in 2024 are more than a legal update; they reshape how disaster and emergency health systems should prepare, activate, and deliver services under pressure. From the perspective of pre hospital and emergency care, the key question is how these changes can be turned into concrete operational gains, particularly for vulnerable populations (1).

Before these amendments, responders faced recurring problems that slowed and fragmented action: ambiguous alert thresholds, unequal access to countermeasures, weak links between public health and emergency services, and uneven integration of digital tools. These gaps translated into delayed incident command activation, late deployment of Emergency Medical Teams (EMTs), and inequitable distribution of vaccines, oxygen, and other critical supplies, especially in low-resource settings. The revised IHR framework directly targets these challenges through clearer alert classifications, strengthened national focal points, and explicit commitments to equity and accountability (1-3).

For emergency and disaster health systems, one of the most practical changes is the clarification of international alert tiers and decision triggers. When mapped prospectively to incident command system (ICS) levels and emergency operations center (EOC) activation postures, these criteria can shorten the time from early signal to surge activation, mutual aid requests, and pre positioning of supplies (1-3). This alignment also provides a common language for cross border coordination, allowing EMTs and hospital networks to synchronize their readiness levels with the evolving international risk

picture.

The amendments' stronger emphasis on equity and solidarity is particularly relevant for allocation of scarce medical products in disasters. By embedding equity considerations into planning, countries can define tiered prioritization schemes for vaccines, diagnostics, oxygen, and personal protective equipment that explicitly favor high risk groups and underserved regions (1-3). When such allocation frameworks are linked to transparent communication and monitored through indicators such as time to delivery, stockout duration, and the share of supplies reaching high need areas, they can reduce predictable inequities in access during peak demand.

The renewed focus on National IHR Focal Points also has direct operational implications for EMT coordination and pre hospital care. Clearer mandates for timely reporting, intersectoral information sharing, and standardized data flows can help bridge the traditional divide between public health surveillance, emergency management, and clinical operations. In practice, this means using common templates for caseloads, severity profiles, bed occupancy, and supply gaps so that EMTs can be alerted, credentialed, and deployed with fewer bureaucratic delays and less duplication of assessment once they arrive (1-3).

Digital and artificial intelligence (AI) tools are recognized in the amendments as potential accelerators of detection, forecasting, and resource management, but only under robust ethical, privacy, and governance safeguards. For disaster and emergency health services, AI enabled forecasting of oxygen demand, intensive care utilization, and staffing needs can enhance surge planning and last mile logistics, provided that models are transparent, auditable, and always subject to human review. Integrating minimal but high value datasets—such as case counts, severity markers, bed occupancy, and supply status—into interoperable platforms can support real time dashboards without overwhelming fragile systems (4, 5).

To translate the 2024 IHR amendments into real world capability, emergency leaders should prioritize a small num-

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ber of measurable actions. These include multidisciplinary exercises that explicitly incorporate the new alert tiers and focal point workflows; updates to mutual aid agreements that reflect clarified cross border triggers; and investments in field laboratories, mobile care units, oxygen systems, and cold chain infrastructure aligned with realistic maintenance and staffing plans. Governance measures—such as memoranda of understanding on data sharing, privacy safeguards, and routine after action reviews—are equally important for sustaining trust and learning across events (1-3). From a disaster and pre hospital medicine perspective, the amendments will be judged by whether they shorten the time from signal to response and narrow the gap in access to life saving interventions for the most vulnerable. Systematic tracking of timeliness of detection, deployment latency of EMTs, and equity indicators for allocation can provide a manageable scorecard for continuous improvement. If countries pair the legal changes with disciplined implementation and monitoring, the 2024 IHR amendments can help make future responses not only faster and more predictable, but also fairer for communities at greatest risk.

1. Conclusions

The 2024 IHR amendments provide a concrete operational framework that, if systematically implemented, can shorten the time from early warning to life-saving intervention and reduce inequities in access to emergency care. Pairing legal commitments with measurable actions—such as aligning alert tiers with incident command postures, strengthening national focal point workflows, embedding equity in supply allocation, and deploying ethically governed digital tools—offers a clear path toward faster, more predictable, and fairer disaster and emergency health responses.

2. Declaration

This letter represents the views of the author and does not necessarily reflect the official policy or position of any affili-

ated institution or government body.

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2.2. Conflict of interest

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